

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 05/26/2016
NAME OF PROVIDER OR SUPPLIER JEWEL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 607 VIRGINIA AVE MADISON, IN 47250		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) for Complaint IN00197469 completed on April 13, 2016.</p> <p>Complaint IN00197469 - Corrected</p> <p>Unrelated deficiencies - Corrected</p> <p>Survey date: May 26, 2016</p> <p>Facility number: 004352 Provider number: 004352 AIM number: N/A</p> <p>Census bed type: Residential: 28 Total: 28</p> <p>Census payor type: Other: 28 Total: 28</p> <p>Residential sample: 4</p> <p>The Jewel House was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the unrelated deficiencies and the Investigation of Complaint IN00197469.</p> <p>Quality Review completed by 34233 on May 26, 2016.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE